North Carolina Health Choice (NCHC) Community Care of North Carolina (CCNC)/Carolina ACCESS (CA) Enrollment Form

(To be used only for NCHC children ages 6-18 linked with CCNC/CA provider.)

Please note: ALL information is required to process enrollment form.

PROVIDER INFORMATION

Practice Name as Enrolled in Carolina ACCESS: _____

Carolina ACCESS Practice Medicaid ID#: _____

Telephone # of Practice: _____

PATIENT CONTACT INFORMATION

Date: _____ **Parent/Guardian:** _____

Address of Patient: _____

_____

County: _____ **Telephone # of Patient:** _____

The information below must be **COMPLETED ENTIRELY** to enroll the NCHC recipient in Carolina ACCESS/CCNC:

Recipient Name (as it appears on NCHC card)	Date of Birth	Social Security # (SSN)

Signature of parent/guardian :
As the parent/guardian of a NCHC patient, I have selected this practice/provider as our medical home for the CCNC program..

_____ **Date**: _____

Signature of Enroller (REQUIRED):
By signing below, I certify that I have provided education on Carolina ACCESS/CCNC.

_____ **Date**: _____

Mail or fax the completed Enrollment Form to:
Managed Care Customer Service Center (NCHC 6-18)
DHHS/Division of Medical Assistance
2501 Mail Service Center
Raleigh, NC 27699-2501

Phone: (919) 647-8170 Fax: (919) 715-0844

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